

Mentally Ill Offender Community Transition Program

*Fourth Annual
Report to the Legislature*
December 2001

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MENTALLY ILL OFFENDER COMMUNITY TRANSITION PROGRAM
(RCW 71.24.450 through 460)

BACKGROUND

In compliance with RCW 71.24.460, this is the fourth annual report to the legislature regarding the Mentally Ill Offender Community Transition Program (hereafter referred to as the program). RCW 71.24.455 authorizes this five-year pilot. Funding began July 1998.

The Act articulates the legislative intent for the pilot:

“Many acute and chronically mentally ill offenders are delayed in their release from Washington correctional facilities due to their inability to access reasonable treatment and living accommodations prior to the maximum expiration of their sentences. Often the offender reaches the end of his or her sentence and is released without any follow-up care, funds, or housing. These delays are costly to the state, often lead to psychiatric relapse, and result in unnecessary risk to the public.

These offenders rarely possess the skills or emotional stability to maintain employment or even complete applications to receive entitlement funding. Nation-wide only five percent of diagnosed schizophrenics are able to maintain part-time or full-time employment. Housing and appropriate treatment are difficult to obtain.

This lack of resources, funding, treatment, and housing creates additional stress for the mentally ill offender, impairing self-control and judgment. When the mental illness is instrumental in the offender's patterns of crime, such stresses may lead to a worsening of his or her illness, reoffending, and a threat to public safety.

It is the intent of the legislature to create a pilot program to provide for post-release mental health care and housing for a select group of mentally ill offenders entering community living, in order to reduce incarceration costs, increase public safety, and enhance the offender's quality of life.” [RCW 71.24.450]

Specifically the Act:

- ✍ Charges the Department of Social and Health Services (DSHS) to contract with a Regional Support Network or private provider to provide specialized services to up to 25 mentally ill offenders
- ✍ Sets participant selection criteria

- ✍ Specifies a set of required services
- ✍ Creates an oversight committee composed of representatives from Department of Social and Health Services, the Department of Corrections (DOC) and the selected Regional Support Network or private provider
- ✍ Requires DSHS, in collaboration with the Department of Corrections and the oversight committee, to track outcomes and submit to the legislature a report of the services and outcomes by December 1, 1998, and annually thereafter as may be necessary

The report to the legislature is to include:

- ? A statistical analysis regarding the re-offense and re-institutionalization rate by the enrollees in the program
- ? A quantitative description of the services provided in the program
- ? Recommendations for any needed modifications in the services and funding levels to increase the effectiveness of the program

The program has been in operation for three years of its five-year projected implementation. This report focuses on program implementation, adjustments, innovations and outcomes. All outcome and evaluation results should still be considered preliminary. This report presents data on the participants, services and outcomes as of July 31, 2001.

PROGRAM IMPLEMENTATION

Oversight Committee

As authorized by statute, the oversight committee is comprised of a representative from Department of Social and Health Services, Department of Corrections and King County Regional Support Network. This committee, with a rotating chairperson, operates in a collaborative manner to develop the policies and processes necessary to implement the project. The committee meets at least monthly to review project activities, discuss and resolve issues raised by program staff and generally provide project direction and oversight. A recent example of the oversight committee work is the development of policy to prioritize persons waiting to enter the program.

Program Administration

In August 1998, Department of Social and Health Services contracted with the King County Regional Support Network to develop and implement the pilot program. In September 1998, King County Regional Support Network contracted with Seattle Mental Health and its subcontractors, Pioneer Human Services and Therapeutic Health Services, to provide the statutorily-required service components. The three organizations are licensed mental health and substance abuse agencies with a history of collaboration in providing an integrated program of mental health, substance abuse, residential, vocational and community-based corrections services.

Program Staffing

Seattle Mental Health uses a multi-disciplinary team to deliver integrated treatment services to a broad spectrum of participants. The agency provides services to persons with a variety of clinical diagnoses,

levels of functioning and differing degrees of mental health and substance abuse issues. The program staff includes case managers, the project manager, psychiatrist, nurse practitioner, registered nurse, substance abuse assessor/counselor, vocational specialist and two residential house managers. Staff members have forensic and clinical experience and are skilled at exercising authority, setting limits, establishing appropriate behavioral standards and integrating supportive treatment and behavioral supervision. Most of these staff members devote only part-time to the pilot. The total staffing represents approximately five and one half full time equivalents.

Participant Referral and Selection

In considering candidates for referral to the program, Department of Corrections staff evaluates mentally ill offenders against program selection criteria based on the statutorily mandated elements and good clinical practice. Candidates come from four correctional facilities known as launch sites. Corrections may transfer mentally ill offenders from other correctional facilities to these launch sites for review and consideration. The four launch sites are:

- ✍ Lincoln Park Work Release Program in Pierce County
- ✍ McNeil Island Corrections Center in Pierce County
- ✍ Monroe Correctional Complex in Snohomish County
- ✍ Washington Correctional Center for Women in Pierce County

Department of Corrections institutional staff screens potential candidates for the program, engaging mentally ill offenders to determine their interest and referring candidates for an interview by program case managers. Department of Corrections staff also prepares and sends to King County RSN a comprehensive referral packet that includes the legal history surrounding the offender's crime, mental health assessments from psychiatrists and psychologists and associated clinical information. A selection committee of program, Department of Corrections and King County RSN staff reviews all information, discusses the candidate with a launch site representative and makes the selection decision. The selection of persons with a history of sex offending or of fire setting continues to be particularly problematic. There is a very limited supply of appropriate housing and proprietors willing to accept these offenders.

PROGRAM COMPONENTS

Coordinated Pre-release Planning

The coordinated pre-release planning component has emerged as a crucial element of successful community integration. This phase begins after the selection committee identifies a referred person as eligible, and while the person is still incarcerated. Ideally this phase is implemented three months before the offender's release date.

Pre-release planning includes several components:

- ✍ Convening of a multi-system team that includes the mental health provider, the Department of Corrections (DOC) Community Corrections Officer, prison-based DOC staff, and the chemical dependency provider (when applicable);
- ✍ Developing comprehensive assessments and intakes that incorporate mental health and chemical dependency treatment needs and DOC community supervision requirements;

- ✍ Creating an individualized treatment plan that includes input from the inmate and community-based providers;
- ✍ Applying for entitlements (GAU, SSI, Medicaid) and coordinating start-up with local Community Service Offices;
- ✍ Establishing initial appointments that coincide with the week/day of release;
- ✍ Forming a therapeutic relationship with the offender.

After the initial meetings with the offender and prison-based DOC staff, ongoing coordination of pre-release activities is facilitated through weekly team meetings where issues such as housing needs, medication management, and chemical dependency treatment needs are discussed. The overarching goal is to provide as seamless transition to community life as possible.

Participant A: *The participant is a 35 year old female Caucasian with a history of multiple suicide attempts. In addition to significant drug addiction issues, her criminal history includes the commission of at least 36 crimes. Her diagnoses include Post Traumatic Stress Disorder (PTSD), Depression, Borderline Personality Disorder, and Polysubstance Dependence. While she was still incarcerated and receiving pre-release services, she made a good connection with her case manager during weekly visits. During this phase, she completed mental health and chemical dependency evaluations conducted by program staff. She met her assigned Community Corrections Officer, and was assured to learn she could count on continued support and services after her release to the community. Since release, this woman has obtained part-time employment, has no supervision violations, has made no suicide attempts, and remains alcohol and drug free – all of which is a remarkable contrast to her former life. Program staff strongly believe this woman has benefited significantly from the relationships that were established and the work that was done during the pre-release stage. This is the first time this woman has ever participated in treatment and support services, and is the first time she has remained stable following incarceration.*

The program served a greater proportion of participants with complicated profiles throughout the last year. An increased number of participants presented with complex and multiple psychiatric diagnoses, histories of serious sex offenses, challenging personality disorders, fetal alcohol syndrome, and untreated medical problems. This resulted in the program seeking out innovative and specialized services to address these issues.

Participant B: *This participant is female, and came to the program from the Women's Correctional Center. Her crime was first degree rape of a child. Her mental health diagnoses include panic disorder, major depression, pedophilia, and mixed personality disorder. She has medical problems that include diverticulitis, asthma, irritable bowel syndrome, migraine headaches, and seizure disorder. In addition, this participant has a history of abusing prescription drugs. The program contracted with a sex offender treatment provider to provide individual and group treatment and regular polygraph testing. She is receiving chemical dependency treatment and neurological testing for her seizure disorder.*

Intensive Post-release Case Management

The first week is a vulnerable time for most participants. It is well documented that participants are highly susceptible to chemical dependency relapse at this time. To mitigate this risk, participants are asked to

agree to remain at his/her residence during the first week, unless accompanied by a case manager or attending a nearby appointment.

This phase begins on the day of offender's release to the community. DOC staff transports the released offender (now referred to as "the participant") to his/her housing. In most cases, newly released participants are initially housed at a specialized supported living facility. When the participant arrives, he/she is met by his/her case manager and introduced to the house manager. The participant's first day in the community is typically a busy one. The case manager takes the participant shopping for clothing, bedding, cooking implements, food, cleaning supplies, and personal care items. The participant usually has an intake appointment at the DSHS, Community Service Office ¹ so that financial resources can be available immediately.

The second day usually includes an appointment with a health care provider, obtaining legal identification, having a DOC community intake appointment, and meeting program staff members who are part of the participant's team.

During the remainder of the first week, the participant typically has initial appointments with his/her chemical dependency treatment provider and with psychiatric services. Some participants have significant mental health symptoms and/or compromised levels of functioning; consequently, strategies are employed to assist such participants to transition to the community at a pace that is compatible with their abilities. For participants who have limited daily living skill, such as how to shop, cook, or take care of personal hygiene needs, their case manager will immediately provide coaching and skill building. For those who become confused or get lost when trying to get to appointments the case manager will walk with them until they can find their way or are no longer overwhelmed.

The intensity of the first weeks' activities sets the stage for implementing the ongoing services identified in the participant's individualized treatment plan. As the participant successfully achieves treatment goals and objectives, they are encouraged to become more independent. A transition plan is developed that maps strategies for achieving greater self-determination and reducing dependence on formal systems. Elements of this plan might include living in a less structured housing environment, engagement in educational and employment activities, and increased self-monitoring of medications.

Outreach and engagement: For some participants, the combination of severe mental illness, past criminal behaviors and other factors, result in significant resistance to engage in the treatment and services needed to achieve individual and community stability. Some are subject to mental health decompensation, chemical dependency lapse/relapse, and/or periods when the participants whereabouts are unknown. In these situations, program staff provide outreach and engagement services designed to establish trust in the treatment team and acceptance of services. Staff engages the participant wherever he/she may be: in jail, on the streets/in shelters, in hospitals, or detained by Immigration & Naturalization Services. For some, the intensity of the program is more than they can tolerate, so enrolling them in "mainstream" services may be the best option.²

Structured Programming: The program design incorporates attendance at a minimum of five group sessions per week. These groups are lead/co-facilitated by mental health and chemical dependency professionals and by community corrections officers. Assertive mental health treatment is tailored to individual needs, includes at least one group and one individual counseling session weekly, home visits at

¹ Financial applications are completed while the participant is still incarcerated, but face-to-face intakes are still required before entitlements can be dispersed.

² The program is mandated to serve no more than 25 participants at a time, so moving some participants to less intensive services may provide an opening for participants who can benefit from intensive services.

least two times per month and other structured activities. Counseling sessions focus on relapse prevention, and case management addresses requirements for meeting all court-ordered conditions. The team reports any violations to the community corrections officer.

For participants who receive intensive outpatient chemical dependency treatment, specialized groups are provided. Participants are encouraged and assisted to develop natural supports through Alcoholics Anonymous and Narcotics Anonymous. If participants want a faith-based connection, program staff helps the participant to locate a culturally appropriate faith-based community. Program staff also helps participants re-establish family connections, when appropriate.

When participants are first released, their medication compliance is monitored on a daily basis – participants come to the clinician's office where medications are dispensed and the participant is observed taking them. Some participants are actually given a financial incentive to encourage compliance with their medication regime.

Crisis Response: Program staff and the DOC Community Corrections Officer have developed a 24-hour crisis response protocol for all participants, each of whom has an individualized crisis plan that identifies risk factors, strategies that address community safety concerns, and recommended interventions. This plan is electronically available to the after-hour crisis response team, and includes access to a community corrections supervisor (for those participants who have community supervision) who may provide consultation and assistance with interventions as needed.

A number of program participants have histories of rapid decompensation that can foreshadow assaultive behavior. When this appears to be occurring, program staff immediately assess whether voluntary or involuntary hospitalization seems indicated. County designated mental health professionals often provide consultation, including crisis interventions that may mitigate hospitalization or involvement in criminal behavior. In some cases, however, hospitalization is the appropriate option.

Residential Support Services

The program continues to provide a housing subsidy up to a maximum of \$6,600 per participant/per year. SMH contracts with Pioneer Human Services, an organization specializing in providing housing to former offenders. Most participants are initially housed in a transitional housing facility when they are first released from prison.³ This house has an onsite house manager, provides ongoing monitoring of residents, and provides offices for clinical services. As the participant achieves greater community stability, he/she may be able to move to less structured housing, which is an important step toward further independence.

Some participants are so cognitively and/or functionally impaired that full participation in program activities is not a realistic expectation. It is particularly challenging for these participants to acquire and implement the set of skills needed to live in transitional or independent housing, i.e., shopping, cooking, cleaning. Residential facilities that provide meals and other supports needed for activities of daily living may be a better option. Placement in such facilities allows the program team to focus on helping the participant to improve his/her mental health symptoms and address other immediate treatment needs. When participants achieve greater stability, acquiring activities of daily living and community living skills can then move to the forefront.

³ Some participants are excluded because of their criminal history. For example, the transitional house is not accessible to those who have committed a sex offense because of its proximity to a grade school.

Community Safety

Community safety is the highest priority for the program. The program team meets with participants a minimum of five times a week and regularly conducts risk assessments. If a participant is experiencing psychiatric decompensation, a psychiatrist sees the participant on an emergency basis. Staff closely monitors medication and coordinate with the psychiatrist to stabilize the participant.

The vast majority of program participants have a history of substance abuse or addiction. Relapse among these participants is of special concern, particularly when the participant has a history of engaging in criminal conduct while under the influence of substances. The program staff assesses risk to the community in each instance of relapse.

Community Supervision

Although community supervision is not a requirement for program eligibility, most participants have at least minimal supervision requirements. The Special Needs Unit of the King County DOC office has assigned a designated Community Corrections Officer to work with the project. This assignment has fostered cohesiveness amongst team members, and collaboration between the treatment and community corrections systems. Community supervision appears to have positive impact on successful reintegration due to the unique role the Community Corrections Officer plays on the participant's team. The Community Corrections officer:

- ✍ is an integral part of the treatment team, and treatment plans can include strategies to assist the participant to meet community correction requirements;
- ✍ has the authority to arrest/detain participants for infractions, which can provide a strong reminder to participants to comply with conditions of release and avoid re-offense;
- ✍ can add a corrections perspective to crisis response;
- ✍ has the authority to conduct random UAs for participant's with a history of substance abuse, or when current substance abuse is suspected – this can lead to pre-emptive interventions that may preclude incarceration;
- ✍ can conduct room searches to locate drug paraphernalia when there are concerns;
- ✍ can make recommendations in disciplinary hearings that include input from the participant's team; and
- ✍ can enforce treatment compliance if this is a condition for release.

Participant C: *This participant is a 42 year old Caucasian female who has been diagnosed with mood and factitious disorders, pedophilia, borderline personality disorder, as well as numerous medical problems. Since her release from prison, this client has been resistant to participating in the program, but neither program staff or the CCO have given up on her. Because of the various problems she has, this client has number of treatment providers (e.g. medical, mental health, sex offender). She has been known to tell one provider that another provider says she doesn't need treatment. She has put forth numerous excuses as to why she should be excused from group and individual sessions, and is frequently out of compliance with her community supervision requirements. This behavior has endured for many months, and throughout the role of the CCO has been essential to keeping this client engaged at any level. At one time the CCO sat down with the client and all providers at the same table and drew up a behavioral contract, thus eliminating any possibility this client could tell different stories to each provider. When she continued to violate her supervision requirements, the CCO*

involved all providers in developing strategies and consequences to her violations. As a result, this client was given additional community supervision hours. The CCO then worked with her residential house manager and treatment providers to support the client in achieving these additional requirements. When the client did not follow through, the CCO finally resorted to jailing her for 30 days.

While this client may not meet traditional definitions of success, it is clear that without the support and involvement of the CCO --and community supervision requirements -- she would never have engaged in the program or other services at all. She now remains connected to program staff, an achievement unparalleled in her previous history.

A particularly valuable role for the community corrections officer is invoking disciplinary measures when a participant violates conditions. One effective strategy involves temporary incarceration at Lincoln Park, a DOC work release facility in Tacoma that has onsite mental health and chemical dependency counselors. The treatment team continues to work with the participant during temporary incarcerations, the participant experiences the placement as less punitive, and the community provider and facility staff are able to coordinate treatment strategies. The work release environment allows the participant to leave the facility for approved reasons while still providing a highly structured setting.

Co-occurring Disorders (Mental Health and Substance Abuse) Treatment⁴

Seattle Mental Health contracts with Therapeutic Health Services, a licensed chemical dependency agency, to provide chemical dependency assessment, treatment, referral, and consultation services for program participants. Therapeutic Health Services offers a range of treatment services that meet the complicated needs of ex-offenders, and their clinicians work as an integral part of the participant's treatment team. In the last year program participants participated in such services as methadone treatment, men of color groups, women's groups, and individual counseling.

Nineteen program participants participated in Therapeutic Health Services services this year. The following provides a survey of treatment and services accessed by these participants. Brief case scenarios will illustrate the wide variety of treatment modalities used by the program treatment coordinator and other Therapeutic Health Services staff.

Ex-offender addicts, special population concerns and characteristics: Previous unsuccessful treatment efforts with chemically dependent offenders in transition have focused on the more general characteristics that this population shares with all addicts. Ex-offenders show the same perception problems (i.e. entrenched denial systems), lack of knowledge of the health impact of drugs, and continued emotional entanglement with active users and codependency issues that all recovering addicts deal with. It is common for ex-offenders to quickly exit treatment programs that only address these issues.

Successful work with this group of recovering individuals includes strategies that attend to the unique characteristics of ex-offenders. Therapeutic Health Services treatment strategies address:

1. The immediate use syndrome – Most offender addicts employ fantasies of using drugs immediately upon prison release to help them cope with the daily routine of prison life.

⁴ As integrated mental health and substance abuse treatment plays an ever increasing role in the program this report provides a fuller description of the substance abuse treatment than has been provided in previous reports

Strategies such as early intervention with offenders (assessments/individual sessions) during the pre-release phase provide a bridge to a life that is not centered on the use of substances.

2. Non-incrimination theme – Many offenders avoid discussions about aspects of their personal or family drug use history due to longstanding beliefs that discussing this information will lead to incrimination (or incrimination of loved ones) in further crimes. Strategies such as milieu treatment with ex-offenders have come to terms with their past can lead to the abandonment of denial systems.
3. Overt compliance – Some offenders have familiarized themselves with recovery jargon but do not truly attempt to make lifestyle changes. Frequent urine analysis, family involvement, peer group feedback, and the use of non-traditional counseling techniques helps participants develop a deeper understanding of drug addiction recovery.

The table below summarizes the interventions/treatment activities program participants utilized the past year.⁵

Treatment group/services	# of MIO CTP clients involved
Men's group	5
Women's groups	5
Men of color	3
Women of color	0
Alcohol/drug/Cocaine intervention & education	6
Aftercare groups (Recovery problem-solving, recovery discussion, and relapse prevention)	10
Intensive Out Patient (intensive group work involves 3 or more groups per week & individual counseling)	6
Individual counseling (2-4 x/month)	18
Alcoholic Anonymous or Narcotic Anonymous community meetings	17

The following scenarios depict some of the approaches utilized to achieve meaningful behavior changes with program participants.

Participant D: This participant is a young African American woman who has just been released after her first long incarceration. The participant is highly gang involved and is addicted to marijuana and crack cocaine. The individual and group counseling intervention focused on renewing community membership, spirituality and family connections. This approach helps the participant achieve life goals without relying on gang ties.

Participant E: This participant is a thirty-six year old European American female diagnosed with borderline personality disorder, with a history of self-mutilation, cocaine use, and prescription drug abuse. The participant's tendency to become inappropriately involved with male program participants was sidetracked by placement in women's groups. These groups help her to focus on positive alternatives to reliance on drugs/alcohol/self-mutilation. Individual counseling involved use of Dialectic Behavioral

⁵ Counts duplicated because participants may have participated in one or more treatment intervention.

Therapy, a therapeutic intervention particularly effective with chemical addicted people with borderline personality disorder.

Participant F: *This participant is a middle-aged European American male with a history of psychosis and amphetamine use. Although initially very isolated and paranoid, this participant became an active participant in drug education groups. His participation was facilitated by the use of a structured group environment that did not invoke anxiety. Individual sessions focused on separating delusional material from the real recovery progress the participant had achieved.*

Although the program participants represent a very small sample of ex-offenders, clear trends point to the success of the specific chemical dependency treatment strategies used with participants enrolled in the program. Of 19 offenders involved in Therapeutic Health Services treatment, only three have used drugs or alcohol immediately upon release from long or short-term incarceration. Within this group 17 participants were able to begin discussing their family/personal drug use histories in detail, which research has shown to be a key element of recovery. Of additional benefit is the strong connection many participants have developed to their treatment group, which provides an element of social support and connection.

Employment services

While not all of the participants have obtained employment, the involvement of specialized vocational staff increases motivation and interest in becoming more productive. Participants have worked in such varied employment settings as construction companies, dental offices, coffee houses and restaurants. Some have worked for private industry while others have done volunteer work as a step toward gaining marketable skills. A number of clients have pursued educational programs, such as completion of GED's, dietician programs, and musical studies. The program connects those who may not yet be able to work or attend school with Emerald House, a Club House program sited at Seattle Mental Health. This is a participant run day treatment program. Additional information on employment services is presented in the Innovations section of Program Successes and Innovations [Page 14].

Transitions

The pilot project design calls for participants to transition from the intensive service level of the program to the "mainstream" publicly-funded mental health system, when it becomes appropriate. Timing of transitions depends on a number of factors: whether the participant continues to have community supervision requirements; the ability of the participant to manage his/her mental health and/or chemical dependency issues without the intensity offered by the program; whether affordable, appropriate housing can be provided without the subsidies provided by the program; and whether the person has requested less intense services.

According to the contract under which this program was established, the King County RSN may immediately terminate from the program any person arrested, civilly committed under Chapter 71.05 RCW or returned to the physical custody of Department of Corrections. Additionally, statutory language allows Department of Corrections to terminate other participants as necessary. Terminations typically occur through a process initiated by program staff. Recommended terminations are consistent with statutory requirements, and may also include other circumstances, i.e., the participant has disappeared and can't be located or the participant is Absent With Out Leave from a work release facility.

Requests for termination are generally presented by the Program Manager to the Oversight Committee for review and discussion. The Oversight Committee considers whether the request meets statutory requirements, and makes a final determination. Program staff are strongly committed to re-establishing therapeutic relationships with those participants who are willing and able to return to the program. If a terminated participant requests readmission, that person is provided with priority review for reinstatement by the Selection Committee.

There were a number of successful transitions from the program this year. The following are two examples:

Participant G: *This participant is a forty-six year old male whose diagnosis is Schizophrenia, (paranoid type), Schizotypal Personality Disorder and severe diabetes. This participant is a parolee and was incarcerated for 20 years for first degree murder. His cognitive and functional levels, together with his medical issues indicated he could not live on his own. This participant was in the program for two years and completed all phases of treatment. Appropriate housing was difficult to find, but eventually he secured a bed in a group home and is very happy there. He recently called to thank the Seattle Mental Health staff for all the assistance he received over the past two years. He continues to receive Mental Health services in the area he now resides.*

Participant H: *This participant is a thirty-six year old woman with mental health diagnoses Post Traumatic Stress Disorder (PTSD) and Psychosis NOS. She was incarcerated for assault with a deadly weapon. Her time in the program was not without difficulty – while enrolled she was temporarily incarcerated in the King County Correctional Facility. However, after stabilizing psychiatrically, she eventually completed the program and returned to school. She applied for and received an apartment subsidized by the Seattle Housing Authority. She successfully terminated from the program and continues to receive mental health services.*

The majority of participants who terminated from the program continue to receive mental health services through the King County Prepaid Health Plan, regardless of whether the participant completed the program or left prior to completion.

PROGRAM SUCCESSES AND INNOVATIONS

Successes

Each year since the program's implementation, new approaches and resources are identified and implemented to inform a best practice model for eligible mentally ill offenders. These efforts are often based on particular issues brought to the forefront by the presenting problems or needs of individual participants.

The enhanced ability to work across systems continues to be a major asset toward successful community transition of program enrollees. Representatives from each system have gained considerable knowledge about how other systems work – the mission, goals, regulatory requirements, and activities provided to work with participants. This knowledge, in addition to the personal connections that have been made, leads to improved continuity, unified cross-system efforts, clear communication, and a more comprehensive approach to work with participants.

The program was honored to receive the 2000 Exemplary Service Award from the King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) in the Service Innovation category. This recognition at the local level reinforces the perceived value of the program to the community, as well as the unique expertise the program provides in its work with participants.

The program has shared information, successes, and challenges in a number of ways this past year:

- ✍ The program is represented on the King County System Integration Advisory Committee, a work group that seeks to improve access to, and quality of, integrated mental health and chemical dependency services.
- ✍ Each calendar quarter, the program is presented to individuals from a broad array of organizations (criminal justice, inpatient, community mental health, drug/alcohol providers) from across the United States and Canada who visit King County to learn more about the continuum of care developed to address the needs of mentally ill offenders.
- ✍ Seattle Mental Health, the lead agency for the program, used the expertise developed through this project and its involvement with the Dangerously Mentally Ill Offender program to develop a Forensic Mental Health Department. This department provides specialized services to individuals with mental illness who have also been involved with the criminal justice system (not just those served through special projects). At least one other mental health agency in King County is following suit.
- ✍ Program staff continue to work with the King County Community Corrections Mental Health Advisory Committee, a cross-jurisdictional group that identifies solutions for the needs of the hardest to serve mentally ill offenders. This committee includes a federal probation officer, a mental health court probation officer, a mental health provider, a county designated mental health professional, a King County RSN representative and the supervisor of the Department of Corrections Community Corrections Special Needs Unit.
- ✍ Program staff continues to participate in the King County Incarceration Workgroup, which works on resolution of problems between community and correction staff, improved communications and procedures for developing collaborative treatment and discharge plans.
- ✍ Program staff continues to attend monthly Co-Occurring Disorder breakfasts sponsored by King County Mental Health, Chemical Addiction Division. During these breakfast discussions, mental health and substance abuse providers share resource information, identify system and programmatic gaps and suggest solutions to common problems.
- ✍ Program staff met with a statewide group that developed rules for Chapter 75, Laws of 2000 (SSB 6487) that guides information sharing about individuals served by the DOC and DSHS.

- ✍ The program will present at the upcoming “Collaborating for Success” – the third annual conference on mentally ill offenders, jointly sponsored by the DOC, the Washington Institute for Mental Illness Research and Training, and the Mental Health Division, DSHS.
- ✍ Program staff continues to be available to King County treatment providers as trainers and case consultants.
- ✍ The RSN assisted in the development of a grant proposal developed by the city of Seattle for a Federal Young Offenders Re-entry Project.

Innovations

The program developed numerous innovations this past year that improved the range, availability, and appropriateness of services to participants.

- ✍ Use of Multi-System Care Plan for pre-release planning. The program began using the Multi-System Care Plan, developed for the Dangerous Mentally Ill Offender program, during the past year. This tool improves overall documentation of the pre-release care plan. Of particular value is input from institution-based DOC staff that provides information and concerns about inmates prior to the first pre-release meeting.
- ✍ Protocol development: Two protocols used in day-to-day operations were developed.
 - ? The first is a wait list protocol, which became necessary when the program reached capacity earlier in the year. The program Selection Committee, comprised of representatives from King County, the mental health provider, the substance abuse provider, DOC community corrections staff, and DOC staff from referring prisons developed a draft priority criteria which was then submitted to the Oversight Committee. The Oversight Committee suggested minor modifications and approved the proposal, which will be subject to review before the end of the year.
 - ? The second protocol modifies contents of the referral package and cover sheet sent by the referring prisons. The changes reflect documents in current use (and eliminates out of date documents), and also reflect a better understanding of the type of information needed to approve a referral and to provide appropriate information about a potential participant. These modifications were also developed by the Selection Committee and approved by the Oversight Committee.
- ✍ Improved access to entitlements: The program participated in a work group, which included a local representative from Social Security, that reviewed policies and procedures for access to entitlements for homeless and mentally ill people.
- ✍ Co-occurring disorders: King County RSN developed a pilot project with Pioneer Center North (PCN), the State’s inpatient site for chemical dependency civil commitment, to directly admit certain participants directly to PCN from prison.

The new commitment criteria that addresses grave disability should increase access to this service site for participants who need this level of care without first requiring them to become “treatment failures” within a given timeframe.⁶

⁶ Individuals being released from prison rarely met the previous chemical dependency involuntary treatment criteria which included requirements for receiving community-based treatment at least twice within the previous 12 months.

- ? Lapse vs. Relapse: The RSN, program staff, and the evaluator consulted with Certified Chemical Dependency Specialist and developed definitions and criteria for chemical dependency “lapse” and “relapse”. Previously every episode where the client reverted to using one or more substances “counted” as a relapse, regardless of whether the client had ingested four oz. of beer, or had been on a four week cocaine binge. The new criteria will provide a more accurate portrayal of a client’s risk for relapse.
- ? Employment: In March 2001, an intern from Western Washington University completing a masters program in Rehabilitation Counseling began to work with program participants. This intern met with the program participants identified by program staff as ready to engage in employment at some level. The discussions focused on past work and educational history as information useful to a job search. Based on findings from these discussions, the intern then compiled and coordinated a job readiness training curriculum. These trainings began in May of 2001, are provided in group setting, and focus on providing strategies for obtaining employment. Participants gain skills in identifying jobs to apply for, completing job applications, interviewing, and keeping a job. Beginning in July 2001, this curriculum was made available to other participants with mental illness and criminal histories served by Seattle Mental Health through the Prepaid Health Plan.

Participant I: *This participant is a thirty-one year old Caucasian male. He has a history of 10 prior felonies and 3 misdemeanor crimes. His last incarceration was for a VUCSA (Violation of the Uniform Controlled Substance Act) charge. His mental health diagnoses is Schizophrenia (paranoid type) and Cocaine Dependence. Beginning in April 2001, the intern met with the participant to determine his work and educational history as well as his interests. The participant also attended the group sessions. He received assistance with locating appropriate part time job leads. The participant actively applied for many employment opportunities and received a number of interviews. He is now working in a permanent, part time position.*

- ? Resources for sex offenders: While the program continues to be challenged in locating suitable resources, most particularly housing, for the growing number of enrolled sex offenders, an agreement was recently developed with Interaction Transitions, an agency offering support services and transitional housing to sex offenders, to provide housing for participants that meet eligibility criteria. Staff from this agency and program staff are collaborating on providing wrap around services tailored for mutually served participants.

EVALUATION AND PRELIMINARY OUTCOMES

This section details information about program participants, services and preliminary outcomes during the first three years of the five-year pilot. Consequently, these are interim results. At the end of the five years, the evaluation will compare program outcomes to those in the Washington Institute for Mental Illness Research and Training study of mentally ill offenders. This research, the Mentally Ill Offender Community Transitions Study (CTS), is tracking a cohort of mentally ill offenders individuals released from Washington correctional facilities in 1996 and 1997. Some data from the CTS study, subsequently referred to as the Comparison Group, is included in this report. This study gathered data on mental health services utilization and criminal recidivism over a two to three year period. It represents baseline data on mentally ill offenders in Washington State prior to the implementation of specifically designed and coordinated interventions.

Program Participant Characteristics

Enrolled Participants

This section profiles mentally ill offenders accepted and enrolled as active participants in the program. Of the 54 individuals accepted, two individuals withdrew shortly after enrollment and limited services were provided. One individual was accepted but not yet fully enrolled prior to August 1, 2001. Consequently, the information in the balance of this report reflects data on the 51 individuals enrolled before August 1, 2001 and who have had significant program involvement. In Year I (September 1998 – July 31, 1999) 27 individuals became program participants. Many continued into the second year. In Year II (August 1, 1999 – July 31, 2000) 10 individuals entered the program, and in Year III (August 1, 2000 – July 31, 2001) 14 more persons were enrolled.

Table 1.1 reports the gender of program participants. Twenty-eight program participants (54.9 %) are male and 23 (45.1 %) female. This compares to 92.7 percent male and 7.3 percent female within Department of Corrections.

Table 1.1 Gender of Program Participants

Program Year Admitted	Male		Female	
	#	Percentage	#	Percentage
Year I	15	55.6	12	44.4
Year II	5	50.0	5	50.0
Year III	8	57.1	6	42.9
Total	28	54.9%	23	45.1%

The mean age at release from prison is 35.5 years compared to 34.8 years within Department of Corrections. Table 1.2 displays the age range of program participants.

Table 1.2 Age of Program Participants at Release.

Age group	Year I		Year II		Year III		Total	
	#	Percent	#	Percent	#	Percent	#	Percent
Less than 20	1	3.7	--	--	--	--	1	2.0
20-29	7	25.9	2	20.0	2	14.3	11	21.6
30-39	8	29.6	6	60.0	6	42.9	20	39.2
40-49	10	37.0	2	20.0	5	35.7	17	33.3
50-59	--	--	--	--	1	7.1	1	2.0
60-69	1	3.7	--	--	--	--	1	2.0
Total	27	100%	10	100%	14	100%	51	100%

Table 1.3 details the racial background of program participants. More than half (54.9 %) are minorities, compared to 29.2 percent within Department of Corrections. One-third of enrollees are Black/African American (31.4 %) compared to 22.5 percent within Department of Corrections.

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Table 1.3 Race of Program Participants

Race	Year I Enrollees		Year II Enrollees		Year III Enrollees		Program Total	
	#	Percent	#	Percent	#	Percent	#	Percent
Alaskan Native/American Indian	2	7.4	--	--	1	7.1	3	5.9
Asian/Pacific Islander	2	7.4	--	--	--	--	2	3.9
Black/African American (not Hispanic)	11	40.7	1	10.0	4	28.6	16	31.4
Hispanic	1	3.7	--	--	--	--	1	2.0
White/Caucasian	9	33.3	6	60.0	8	57.1	23	45.1
Other	2	7.4	3	30.0	1	7.1	6	11.8
Total	27	100%	10	100%	14	100%	51	100%

Criminal History and Incarceration Characteristics

This section reports criminal characteristics and incarceration data. Table 1.4 shows the number of felony convictions for program participants. More than two-thirds (70.6%) of program offenders have been convicted of more than one felony. This compares to 77 percent of CTS comparison group subjects having more than one felony conviction.

Table 1.4 Number of participants with multiple felonies

Number of Felonies	Year I Enrollees		Year II Enrollees		Year III Enrollees		Program Total	
	#	Percent	#	Percent	#	Percent	#	Percent
One	10	37.0	4	40.0	1	7.1	15	29.4
Two	5	18.5	1	10.0	5	35.7	11	21.6
Three	8	29.6	2	20.0	2	14.3	12	23.5
Four	1	3.7	2	20.0	3	21.4	6	11.8
Five	2	7.4	--	--	2	14.3	4	7.8
Five +	1	3.7	1	10.0	1	7.1	2	6.0
Unknown	--	--	--	--	--	--	--	--
Total	27	100.0%	10	100.0%	14	100%	51	100.0%

Table 1.5 shows the types of crimes for which program participants were incarcerated. The "Index Offense" is the most serious crime for which the offender was incarcerated just prior to program involvement. This is not necessarily the most serious crime of record. Many program participants have more serious crimes in their histories. The index crime of nearly half (47.1%) of all offenders enrolled in the program is a drug offense. The program admitted a much lower percentage of individuals incarcerated for drug offenses during the second year than during the first year. However, the percentage of third year enrollees incarcerated for a drug offense is closer to first year levels.

Table 1.5 Index Offense Characteristics of Program Participants

Index Offense	Year I Enrollee		Year II Enrollee		Year III Enrollee		Program Total		CTS (N=337)
	#	Percent	#	Percent	#	Percent	#	Percent	Percent*
Homicide/Manslaughter	2	7.4	--	--	--	--	2	3.9	3
Sex Offense	1	3.7	1	10.0	1	7.1	3	5.9	14
Robbery/Other Violent	8	29.6	3	30.0	3	21.4	14	27.5	24
Burglary/Other Property	2	7.4	4	40.0	2	14.3	8	15.7	24
Drug Offense	14	51.9	2	20.0	8	57.1	24	47.1	29
Other	--	--	--	--	--	--	--	--	5
Total	27	100%	10	100%	14	100%	51	100%	99%

*Reported percentages are rounded to nearest percent.

The most serious crime of program participants is reported in Table 1.6. More than 40 percent of program enrollees have committed a violent offense against a person at some time in the past. One-third (33.3%) have been convicted only of drug offenses.

Table 1.6 Most Serious Offense Characteristics of Program Participants

Most Serious Offense	Year I Enrollees		Year II Enrollees		Year III Enrollees		Program Total	
	#	Percent	#	Percent	#	Percent	#	Percent
Homicide/Manslaughter	3	11.1	--	--	--	--	3	5.9
Sex Offense	1	3.7	1	10.0	1	7.1	3	5.9
Robbery/Other Violent	8	29.6	4	40.0	3	21.4	15	29.4
Burglary/Other Property	3	11.1	4	40.0	6	42.9	13	25.5
Drug Offense	12	44.4	1	10.0	4	28.6	17	33.3
Total	27	100%	10	100%	14	100%	51	100%

The mean length of the index incarceration for all program offenders is 22.8 months (Std D = 20.4.) The mean length of time of incarceration for participants enrolled in program Year II is 21.7 months (Std D = 11.5.) This compares to a Year I average length of incarceration of 18.7 months (Std D = 16.2) (not including two extreme stays of 340 months and 285 months). Year III enrollees who have been released before to August 1, 2001 had been incarcerated for an average of 35 months (Std D = 32.8) prior to release.

While all program participants received mental health treatment while incarcerated, the majority (72.5 %) required residential mental health treatment some time during their incarceration. The balance lived in the general population throughout their incarcerations. This compares to 70 percent of the CTS comparison subjects. For participants who required residential mental health treatment, the mean number of months in a Department of Corrections mental health unit is 13.1 (Std. D. = 12.9) months.

Mental Health and Substance Abuse

Table 1.7 reports the primary psychiatric diagnostic categories of participants at the time of enrollment, as diagnosed by the local service provider. Comparison with CTS subjects is limited. The source of the CTS diagnosis is DOC personnel, the decision tree for diagnostic categories may differ somewhat, and the CTS study was unable to locate a diagnosis for approximately one quarter of subjects.

Table 1.7 Primary Psychiatric Diagnostic Categories of Program Participants

Diagnosis	Year I		Year II		Year III		Total		CTS N=155*
	#	Percent	#	Percent	#	Percent	#	Percent	Percent
Psychosis	11	40.7	7	70.0	8	57.1	26	51.0	31.6
Depression	8	29.6	2	20.0	3	21.4	13	25.5	23.2
Bi-Polar Disorder	7	25.9	1	10.0	3	21.4	11	21.6	34.2
Drug Abuse/Addict	1	3.7	--	--	--	--	1	2.0	--
Other	--	--	--	--	--	--	--	--	11.0
Total	27	100%	10	100%	14	100%	51	100%	100%

* Known principal diagnosis by DOC

Clinicians diagnosed 24 of the 27 (88.9%) Year I participants as having co-occurring substance abuse disorders. Nine of the ten (90%) participants entering the program in Year II have co-occurring substance abuse disorders. All Year III enrollees have been diagnosed with a co-occurring substance abuse disorder. Overall, 92.2 percent of program participants are experiencing substance abuse disorders in addition to the primary serious mental illness. The largest percentage of persons is abusing both alcohol and other drugs.

A number of program participants carry personality disorder diagnoses as well as a major mental illness. Eleven (40.7%) of Year I participants, seven (70%) of Year II participants and seven (50%) of Year III participants are dually diagnosed with a personality disorder. The overall figure is 49.0 percent. Nearly all (92.2%) of these individuals with a major mental illness and a concurrent personality disorder have a co-occurring substance abuse disorder as well.

Program Services

Table 2.1 is a narrative description of program services, providing information on the number of hours of direct service delivered to, and on behalf of, program participants between September 1998 and July 31, 2001. The individual treatment during pre-release usually includes Department of Corrections staff, program staff and the participant. These figures do not include specialized sex offender treatment services that a private provider delivered, and does not include travel time for case management staff.

Table 2.1 Program Service Hours (September 1998—July 31, 2001)

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Service	Year I		Year II		Year III	
	Pre-release	Post-release	Pre-release	Post-release	Pre-release	Post-release
Individual treatment						
Mental Health	79	1713	116	1855	233	1498
Substance Abuse	5	61	--	152	18	175
Group treatment						
Mental Health	45	591	6	544	46	745
Substance Abuse	--	395	--	351	46	881
Drop-in / Day treatment	4	499	--	606	--	977
Treatment Planning (SMH/DOC)	144	336	29	357	106	402
Special evaluations/Consults	32	48	23	66	35	87
Medication management	--	49	--	80	5	64
Total hours	308	3668	163	4011	489	4829

Near the end of the first year the program added a staff member with expertise in co-occurring disorders (mental health and substance abuse) treatment. As a result, the table reports treatment hours by treatment focus (mental health or substance abuse) for Year II and Year III. The table does not fully reflect the amount of substance abuse treatment hours program participants received, showing only those hours program staff provided. Some participants received additional hours of inpatient chemical dependency treatment and/or service hours by other providers not under direct program contract.

Year III service data indicate a shift in focus of treatment services as compared to Year I and Year II. Fewer individual treatment services have been replaced by increased group treatment services. Furthermore, an increase in individual substance abuse services from Year I to Year II has continued in Year III. And group substance abuse treatment has more than doubled in Year III compared to Years I and II.

Outcomes

Meaningful Activity (Work, Education, and Other Structured Activity)

Table 3.1 presents information on meaningful activity on the twenty-three offenders active in the program as of July 31, 2001. These activities are in a constant state of change; consequently, the activity of participants reflects their status at the end of July 2001. Eight program participants were involved in some endeavor directed toward employment or pre-employment activity. One individual was working full time, and one was working part-time. Three persons were in a vocational training program and two more were in school, full or part-time. One individual was participating in Day Treatment on a full time basis.

Of those persons not involved in meaningful employment related activity, five individuals were in pre-release status with Department of Corrections, or recently released and not ready for employment or educational activity. The remaining eleven individuals were exhibiting adjustment problems that precluded vocational or educational activities. Three persons were in intensive outpatient services for substance abuse treatment. Two individuals were in jail and five others were exhibiting adjustment problems that precluded regular meaningful activity, but did not warrant institutionalization.

Table 3.1 Meaningful activity as of July 31, 2001

Employment / Education / Training Status	# of Participants
--	-------------------

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Participants involved in meaningful activity		
? Employed full time	1	
? Employed part time	1	
? Vocational training program	3	
? Educational endeavor	2	
? Day treatment program	1	
	Sub-Total	8
Pre-release and recent release status	Sub-Total	5
Adjustment problem precluding meaningful activity		
? Outpatient intensive substance abuse treatment	3	
? Jail	2	
? Other adjustment problem	5	
	Sub-Total	10
Total		23

Housing

All program participants transitioned from pre-release incarceration into supervised housing arrangements. All received the program housing subsidy to support their housing costs. As of July 31, 2001, the 23 active program participants were living in a variety of circumstances. Five were still with Department of Corrections on pre-release status. Ten were in the highly supervised, video-monitored Berkey House and three were residing in special sex offender housing. One individual had moved to independent housing.

Four persons were living in environments considered inadequately structured for their conditions. These are individuals who have been removed from program housing as a result of repeated rule violations, left structured housing to live with family or friends, or are temporarily in shelter circumstances to prevent homelessness. They remain actively involved with program staff and in treatment, with the goal of stabilizing their behavior. In the meantime, program staff is seeking other housing.

Financial Assistance

All participants, but one, who have been released into the community have had financial assistance arranged shortly after release. Table 3.2 reports the financial assistance for active program participants as of July 31, 2001.

Table 3.2 Financial Assistance as of July 31, 2001

Financial Assistance	Frequency	Percentage
Receiving financial assistance	18	78.3
Not eligible/Pre-release	5	21.7
Total	23	100%

Medical Assistance

Participants apply for medical entitlements shortly after release. Table 3.3 reports these entitlements for currently active offenders.

Table 3.3 Medical assistance as of July 31, 2001

Medical	Frequency	Percentage
Public medical insurance	19	82.6
Pre-release/Application not complete	4	17.4
Total	23	100%

Hospitalization

Table 3.4 displays information regarding psychiatric hospitalization of program participants. As an intervention to prevent further deterioration, 13 of the 51 individuals have been hospitalized for psychiatric reasons. Four additional times, case managers would like to have hospitalized offenders; however, they did not meet criteria for involuntary hospitalization. Of the 13 individuals, one program participant has been hospitalized twelve times, one person has been hospitalized eight times, two have been hospitalized six times, four persons were hospitalized 4 times, two have been hospitalized twice and four persons have been hospitalized once.

Table 3.4 Psychiatric Hospitalization.

Program Year	# of Individuals	# of Hospitalizations		Mean Length of Stay in Days	Range of Stay in Days
		Voluntary	Involuntary		
I	5	10	--	9.7	5-16
II	8	13	3	11.4	2-22
III	5	13	5	13.3	2-68
Total	18*	36	8	11.0	2-68

* represents individuals hospitalized in more than one year

Substance Abuse Relapse

This report defines a relapse very broadly as any episode of alcohol or non-prescribed drug use by a participant with a substance abuse diagnosis. A relapse may constitute a single drink or several days of continuous use. Data comes from a review of clinical records. Table 3.5 shows the number of relapses for participants during their active enrollment.

Table 3.5 Relapse of Participants with Substance Abuse Diagnosis

Number of Relapses	Year I Enrollees		Year II Enrollees		Year III Enrollees		Total	
	N	Percentage	N	Percentage	N	Percentage	N	Percentage
0	5	21.7	6	60.0	6	66.7	17	40.5
1-3	7	30.4	4	40.0	1	11.1	12	28.6
4-6	6	26.2	--	--	2	22.2	8	19.0
7+	5	21.7	--	--	--	--	5	11.9
Total	23	100%	10	100%	9	100%	42	100%

Two out of five participants (40.5 %) with a substance abuse disorder show no evidence of relapse while in the program. Among those persons enrolled after the first year of the program, two out of three have shown no evidence of relapse. Analysis of the number of relapses indicates that Year II enrollees and Year III enrollees have significantly fewer relapses ($F=5.44$, $p=.008$) than Year I enrollees.

Comparisons of the number of relapses are complicated, however. Participants have varying lengths of time in the program. Consequently, a rate of relapse for each group of enrollees was calculated based on the number of participant weeks. (Participant weeks is a concept analogous to man hours and is calculated by multiplying the number of program participants by the number of weeks each was in the program, post-release.) The rates of relapse are presented in Table 3.6.

Table 3.6 Rate of Substance Relapse by Year of Enrollment

Year of Report	Year I Enrollees	Year II Enrollees	Year III Enrollees	Total
December 2000	.09	.04	--	.06
December 2001	.04	.01	.03	.03

The rate of relapse in Reporting Year I was .06 relapses per participant week. The Reporting Year II relapse rate was .03, half that of the first program year. Year II Enrollees had a substantially lower rate of substance abuse relapses compared to Year I participants. Year III Enrollees had a rate of relapse in their first year of enrollment (.03) comparable to Year II Enrollees in their first year (.04.)

The rate of relapse was calculated by program year to assess the impact of program changes. Results are presented in Table 3.7. The rates of relapse during the second and third program years are half the rate of the first year.

Table 3.7 Rate of Substance Relapse by Program Year

Program Year I		Program Year II		Program Year III	
Relapse rate	Std D	Relapse rate	Std D	Relapse rate	Std D
.074	.097	.041	.084	.039	.059

Of the fifty-one participants enrolled in the program, thirty-four (66.7 %) have committed no community corrections violations. Table 3.8 details the number of violations and resulting incarcerations. Participants entering the program during Year I are responsible for 52 of the 64 violations (81.3 percent.) Depending on the severity of the violation and/or the number of violations, participants are incarcerated at the King County Jail or returned to the custody of Department of Corrections. Compared to Year I, in Year II the program used local jails more frequently, and relied less on long term return to the custody of Department of Corrections for sanctioning community corrections violations.

Table 3.8 Community Corrections Violations and Resulting in Incarceration.

Enrollment Year	Number of Individuals with Violations	# of Violations	# of Resulting Incarcerations	Rate of Violations*	
				Mean	S.D.
I	13	52	28	.061	.076
II	2	6	3	.009	.019
III	2	5	3	.014	.030
Total	17	63	34	.039	.064

*Based on number of violations per week of enrollment

Again, comparison between years of enrollment and program years benefit from the concept of participant week rates. Rates for persons enrolled in years II and III are much lower than the rate for Year I enrollees. (Standard deviations of Years II and III indicate great variability of violation rates. This is consistent with a relatively few number of individuals being responsible for most of the violations.)

Violation rates were also calculated for each of the program years. The rates of community corrections violations for the three years of the program are reported in Table 3.9. Violation rates for program years II and III are one the rate for year I.

Table 3.9 Rate of Community Corrections Violations by Program Year of Operation.

Program Year I		Program Year II		Program Year III	
Violation rate	Std D	Violation rate	Std D	Violation rate	Std D
.058	.083	.020	.041	.016	.024

Re-offense

Data on re-offense convictions is from the Washington State Institute for Public Policy database. The database is updated quarterly and results are based on data current through July 31, 2001. Results reported in this section are preliminary.

Results of data on the most serious crime convictions post release by program offenders are presented in Table 3.10, along with comparable data from the CTS study. Eleven program participants have been convicted of fourteen total felony offenses. Of the fourteen felony offenses, seven felonies were drug offenses, five were crimes of property, and two felonies were crimes against a person. Four of the fourteen felonies were committed by one individual, including both felonies against a person.

Table 3.10 Most Serious Offense Committed Post Release.

Most Serious Offense	#	Percentage of Convicted Program Participants	Percentage of all Program Participants (N=47)	Percentage of CTS Comparison Subjects (N = 333)
Homicide/Manslaughter	--	--	--	0.3
Sex Offense	--	--	--	0.6
Robbery/Other Violent	1	7.2	2.1	8.7
Burglary/Other Property	3	21.4	6.4	14.4
Drug Offense	7	50.0	14.9	15.3
Other felony	--	--	--	1.5
Total felony	11	78.6%	23.4%	40.8%
Misdemeanor	3	21.4%	6.4%	20.0%
Total	14	100%	29.8%	60.8%

The length of time until a new crime has been committed is represented in Figure 3.1. More than 70 percent of new felonies committed were done within the first twelve months of release. This compares to approximately 60 percent of CTS felonies were committed within the first 12 months. Thirty-seven of the forty-seven program participants (78.7%) have been in the community more than 12 months. Twenty-seven of the program participants (57.4%) have been in the community more than 24 months. The approximate shape of this curve appears consistent with results found in the recidivism literature and with results of the CTS study. A relatively steep drop begins to level at approximately 12 months from release and becomes nearly flat at approximately 24 to 30 months. Few new crimes are committed after this time period. Consequently, we can begin to have preliminary confidence in the shape of this curve and make a tentative prediction that felony recidivism rates for the program participants will be less than 30 percent.

The meaning of this recidivism rate becomes clearer in comparison to the CTS results of recidivism among mentally ill offenders who were released without specialized intensive mental health services. Adequate comparison of recidivism rates, however, depends on the two groups' relative risk for recidivism. The CTS study found five variables which predict felony recidivism at levels comparable to some of the best prediction strategies reported in the literature. Four of the predictor variables (previous felonies, previous drug felonies, age of first offense, and felony versatility) were applicable to program participants. A comparison of predicted felony rates for the three program years and the comparison group is presented in Table 3.11. Program participants have a very comparable risk for felony recidivism (41.4%) with that of the comparison group (40.8%).

Figure 3.1 Community Survival Rate Until New Felony Conviction

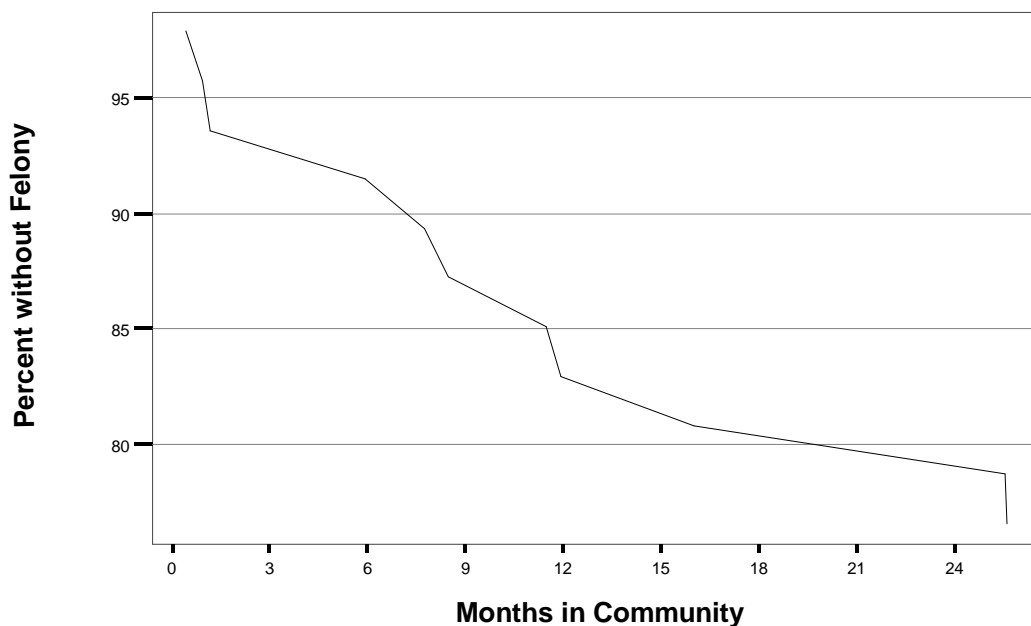


Table 3.11 Comparison of Predicted Felony Recidivism Rates

Felony recidivism rates	Mean for Program Group				Mean for CTS Comparison Group N=333
	Year I N=27	Year II N=10	Year III N=14	Total N=51	
Felony Prediction	37.8%	36.3%	52.2%	41.4%	40.8%
Actual Felony Rate to date	33.3%	0.0%	7.1%*	23.4%	40.8%

* Less than 12 months in community

Based on the predictor characteristics found in the CTS study, program participants' scores on these variables would predict a recidivism rate of around 41 percent. Preliminary results suggest that the Program recidivism rate will be approximately 10 percent to 15 percent lower, than would be predicted, as a result of programming.

Furthermore, there is some evidence that the preliminary projection of 25 –30 percent recidivism may be high, and not reflective of current program impact. Ten of the persons convicted of a new felony were enrolled in the first year of the program. Eight of those ten (80%) committed a felony within the first 12 months. None of the ten enrolled in the second year have new felony convictions in the twelve months since their release, despite similar predictive rates for the two groups, (Year I--37.8% and Year II--36.3%).

A number of first year enrollees had minimal pre-release programming. And significant program changes have taken place since the first year that directly address substance abuse issues. Consequently, there is good reason to believe that second and third year enrollees will have a lower rate of recidivism than first year enrollees as a result of program improvements. On the other hand, third year enrollees have a higher

risk for recidivism than do enrollees for the first two years and this may mitigate the outcomes of the program improvements.

Discharges

Of the 51 persons enrolled in the program, 23 are currently active and 28 have been discharged. Table 3.12 reports the reasons for discharge and reflects various levels of successful participation in programming. Several individuals have requested less intensive services and made planned transitions to other mental health services. While not considered graduations from the program, these individuals are considered successful at a lower level. Some individuals have made unplanned departures from the program and have connected to alternative mental health services on their own. This is considered to reflect some measure of success as well, in that the persons are connected to mental health resources. Persons who withdrew from services in an unplanned manner without connecting to other mental health services, or withdrew from the program prior to release from DOC are considered unsuccessful terminations.

Table 3.12 Program Discharge Information

Reason for Discharge	Year I Enrollee	Year II Enrollee	Year III Enrollee	Total
Successful completion, graduated & transitioned	4	1	--	5
Planned withdrawal to less intensive services	4	1	1	6
Unplanned withdrawal, connected to alternative services	1	2	--	3
Unplanned withdrawal, no services	9	2	--	11
Withdrawal pre-release	--	--	1	1
Not appropriate, misdiagnosed	2	--	--	2
Total	20	6	2	28

CONCLUSIONS AND RECOMMENDATIONS

The results of this pilot program continue to be encouraging. While the outcomes are still preliminary, it appears that this model of providing intensive community services in a highly coordinated and integrated manner offers the promises of increased therapeutic services and increased community protection. While this client population offers significant treatment challenges, most of the persons in the program are actively participating in treatment and the incidents of new offenses are relatively low.

Effective Program Model Design

Four important and effective components of the transition model were identified in the 1999 and 2000 legislative reports. These included:

- ✍ Discharge planning and case management contact with the offender prior to release into the community
- ✍ Intensive case management with a full range of treatment interventions and community supports
- ✍ Appropriate and stable housing
- ✍ Collaboration and coordination across agencies – Departments of Corrections and Social and Health Services Mental Health Division – and across treatment service providers – mental health and substance abuse treatment service providers

Highlighting Effective/Therapeutic Strategies

- ✍ The partnership with Community Corrections Officers has been highly effective in supporting program participant compliance with and participation in programming. While the program has not yet benefited from the Offender Accountability Act, it is clear that the ability of Community Corrections to assure participation in needed services through the Offender Accountability Act will have positive impacts for special needs offenders and on community safety.
- ✍ The program has accessed residential drug and alcohol treatment directly from prison or shortly after release through a pilot project that waived some of the existing eligibility criteria. Many program participants would relapse immediately upon releasing to the community but could not receive needed involuntary residential drug and alcohol treatment because they did not meet the criteria of having failed in two or more attempts at outpatient treatment.
- ✍ The data in the Outcome and Evaluation Section of this report suggests that effective integration of mental health and substance abuse treatment reduces lapse and relapse for year II and III participants. The integration of mental health and substance abuse assessment and treatment did not occur until year two of the program. Year II and Year III participants appear to have experienced greater benefit from the earlier assessment and more integrated interventions.
- ✍ Lincoln Park Work Release facility has been utilized by the program as a “step-down” facility prior to program participants release from custody to assist program participants in acclimating to returning to the community following their incarceration. The participant experiences much of the structure that they had in the prison within a community-based setting. The work release facility has also been utilized in lieu of a return to prison when a program participant violates a condition of their release. In both cases the program staff come to the work release facility to engage the program participant and provide treatment.
- ✍ The program has found that the effective use of psychiatric hospitalization (both voluntary and involuntary) for early intervention promotes both a healthier and more stable program participant as well as community safety. Therefore, despite an overall program goal of reduction of institutionalization, the program actively seeks to utilize hospitalization as an intervention of choice for individuals who appear to be exhibiting symptoms that have in the past lead to criminal behavior.
- ✍ Integrating a sex offender treatment specialist unto the staff team of the program has been most beneficial to program staff learning how to intervene earlier and more effectively address the needs of and community safety risks presented by program participants who are sex offenders. It has also provided the program with increased knowledge of where housing might be available for these participants.

Challenges and Issues Needing Continued Problem-Solving

As the program continues to mature, it has become clear there are issues and resource gaps that, if addressed, would improve our ability to appropriately meet the needs of program participants and consequently, improve public safety. Four issues/barriers are discussed in this section: housing, support systems, medical problems and liability.

Housing

Foremost among barriers is the lack of appropriate housing for program participants with particular profiles/criminal justice histories. There are numerous factors that contribute to this issue, and the factors can vary by participant. The factors that cause barriers to housing include: eligibility criteria that exclude felony offenders; participant characteristics that pose a liability to landlords and communities; the need to live in a staffed residential program but behaviors that make congregate living unsafe; and the lack of

affordable housing stock. To address the issue at a local level King County RSN initiated a housing work group to study the issue and make recommendations both to local and state officials.

Support Systems

Family, friends, and other members of support systems are often the anchor for the mentally ill clients. A noticeable difference for the mentally ill offender is the lack of such supports. Families often do not want contact with the clients, or the client feels too ashamed to contact his/her family. While program staff try to restore contact with families, success is limited. In many cases bridges are burned. As for friends, many clients need to break ties with former friends who were tied to their criminal behavior and/or substance abuse, and clients find it very difficult to build trust with or become accepted by those who are unknown to them. This often results in feelings of loneliness and isolation, which again place the client at risk. The program has organized outings for the clients, and has received gifts of tickets to baseball games, passes to the zoo and the aquarium. These outings are helpful in building social contact and provide wholesome outlets for enjoyment, but are an incomplete solution to the need for social networks that are not solely comprised of paid professionals and other clients.

Medical problems

The program is experiencing a significant increase in clients with serious medical problems. Examples include:

- ✍ serious dental problems;
- ✍ severe diabetes;
- ✍ seizure disorders;
- ✍ neurological defects; and
- ✍ HIV.

Because of these issues, the program is has significantly increased collaboration with health care providers, including specialized clinics and hospitals. Health care issues must often take precedence over other treatment needs, require extensive resources to manage, and divert clinicians from other program efforts.

Liability

The long term issue of liability remains a concern for the program. There are continued efforts to refine contract language between the Mental Health Division and the Regional Support Network, and between the Regional Support Network and the provider, to mitigate liability risks associated with providing services to persons who are at risk of causing harm to the community. The program's challenges related to liability are most significantly exemplified in the inability to secure/purchase sex offender treatment for some of the program participants because the sex offender treatment providers refuse to treat the program participants as they are considered too high of a liability risk. Similarly, in the Dangerous Mentally Ill Offender Program some Regional Support Networks and the community providers are not able to get liability insurance coverage, or not at an affordable price, to provide services for individuals identified as Dangerous Mentally Ill Offenders releasing to their communities. This issue is going to continue to need problem solving efforts both at the local and state levels.

Utilizing Lessons Learned

The lessons learned during the first years of the pilot project are being directly applied to the treatment implementation and planning of other areas.

- ✍ Implementation strategies for Chapter 214, Laws of 1999 (SB 5011) “Dangerous Mentally Ill Offender” (DMIO) legislation reflect the program design and innovations. Of particular value is the pre-release work in the prisons with mentally ill offenders, which increases the likelihood of offenders becoming immediately and effectively connected to services when they return to the community. The DMIO protocols and contracts with the RSNs call for and fund a pre-release phase. The DMIO Implementation Committee also recognized that the cross system collaboration developed by the program is an essential component to working with this population. The lessons learned in the program regarding the prevalence of chemical abuse and dependency among mentally ill offenders also impacted the policy development and planning for DMIO services.
- ✍ The design of the new co-occurring disorder pilot program for youth (funded in the 2000 supplemental budget) resembles the program in that it will include a two-month pre-release component and post-release treatment of juvenile offenders with co-occurring disorders. Like the program, this pilot project features small caseloads, cross-system treatment teams and substance abuse treatment.
- ✍ The Department of Social and Health Services-Department of Corrections Cross System Collaboration on Co-occurring Disorder Services to Offenders is developing a plan to address the complex treatment needs of the offender with co-occurring mental health and substance abuse disorders. The collaboration will examine the integrated mental health and substance abuse treatment services model from the program as part of this plan development.

Interim and Preliminary Outcomes

Information from the evaluation section of this report reflects program model changes and provides data to support the effectiveness of these changes.

- ✍ Pre-release planning and services have increased over the course of the three years of implementation. Concurrently, the rate of community corrections violations during years II and III are one-third and one fourth, respectively what they were during the first year.
- ✍ Individual and group treatment of substance abuse has increased in years I and II, relative to individual and group mental health treatment. Concurrently, the rate of relapse among program participants has dropped significantly. The rate of relapse in years II and III are half what they were during the first year of the program.

Preliminary outcome data on recidivism suggests that the program will reduce felony recidivism among mentally ill offenders, as compared to a similar group of offenders released in 1996 and 1997.

At the present time, 23.4 percent of program participants have been convicted of a new felony. The data suggests that the felony recidivism rate among program participants is likely to reach 25 percent over the course of two years. However, when compared to a 41 percent felony recidivism rate among similar offenders without specialized services, this represents a 35-40 percent reduction in felony recidivism

Recommendations

- ✍ Continue to fund this pilot project at current levels
- ✍ Continue to explore innovative solutions to the identified major challenges
- ✍ Consider ways provide the key model elements and the strategies to all mentally ill offenders

The remaining two years of this five-year pilot will yield invaluable information regarding the efficiency and effectiveness of various innovations and integrations designed to meet the legislative objectives “to reduce incarceration costs, increase public safety and enhance the offender's quality of life.” As has been true since its inception, the program will continue to keep a focus on strengthening the collaboration across systems and meeting the complex needs of mentally ill offenders with multiple co-occurring disorders.